

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### **GENERAL INFORMATION**

### **Requestor Name and Address**

TENET HEALTHCARE 2401 INTERNET BLVD STE 110 FRISCO TX 75034-5976

**Respondent Name** 

Sentry Insurance A Mutual Co

**MFDR Tracking Number** 

M4-12-0401-01

Carrier's Austin Representative Box

Box Number 19

**MFDR Date Received** 

October 6, 2011

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "After carefully reviewing the last explanation of benefits dated 07/21/11, it has been determined that the original payment of \$5892.94 is an underpayment. This claim should be paid per the Workers Compensation guidelines, which abides by the Medicare reimbursement rate plus a 200% markup."

Amount in Dispute: \$269.12

# RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The billing was then reduced according to their PPO contract AT 80% OF BILLED CHARGES OR 95% OF THE AMOUNT ALLOWED UNDER STATE GUIDELINES OR W/C FEE SCHEDULE, WHICHEVER IS THE LESSER CONTRACT ALLOWABLE.S"

Response Submitted by: Sentry Insurance

### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2010	Outpatient Hospital Services	\$269.12	\$249.92

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
- 3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
- 4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 21, 2011

- 1 (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 2 (45) Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 3 (W1) Workers Compensation State fee Schedule Adjustment.
- 4 (96) Non-covered charge(s).

### <u>Issues</u>

- 1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
- 2. What is the applicable rule for determining reimbursement for the disputed services?
- 3. What is the recommended payment amount for the services in dispute?
- 4. Is the requestor entitled to reimbursement?

# **Findings**

- 1. The insurance carrier reduced or denied disputed services with reason code 45 "Charges exceed your contracted/legislated fee arrangement." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines
- 2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
- 3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 72020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$23.05. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$41.01. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$41.01. This amount multiplied by 200% yields a MAR of \$82.02.
  - Procedure code 63030 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0208, which, per OPPS Addendum A, has a payment rate of \$3,318.10. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,990.86. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$1,703.18. The non-labor related portion is 40% of the APC rate or \$1,327.24. The sum of the labor and non-labor related amounts is \$3,030.42. The cost of these services

does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$3,030.42. This amount multiplied by 200% yields a MAR of \$6,060.84.

- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7060 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code S0028 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- 4. The total allowable reimbursement for the services in dispute is \$6,142.86. This amount less the amount previously paid by the insurance carrier of \$5,892.94 leaves an amount due to the requestor of \$249.92. This amount is recommended.

# Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$249.92.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$249.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

## **Authorized Signature**

		April 11, 2013	
Signature	Medical Fee Dispute Resolution Officer	Date	

#### YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.